

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17395 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17406	
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last ELIZABETH R. AYARS					2a. DATE OF DEATH Month Day Year 12 8 1968			2b. HOUR 3:30 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 6, 1893		6. AGE (In years lost-birthdays) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL			Md.		
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY USA			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY CECIL		13c. CITY OR TOWN ELKTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD #4		
14. FATHER'S NAME First Middle Last PORTE V. RANSOM.			15. MOTHER'S MAIDEN NAME First Middle Last ELELYN BYRD HILL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (wn) No			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Address PRESTON AYARS SR. ELKTON, RD#4 MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease										1 mo 1 mo. Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 11-8- , 19 68 , to 12-8- , 19 68 , that (I) (we) last saw the deceased alive on 12-8- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE T. Hansen D. Schusen M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-9-68				
22d. PHYSICIAN'S NAME (Type) T. Hansen D. Schusen M.D.					22e. ADDRESS 123 S. Sycamore Ave. Elkton, Md						
23a. BURIAL CREMATION (Specify) BURIAL		23b. DATE 12-11-68		23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEM.			23d. LOCATION (City or Town) (County) (State) WILMINGTON, NEAR DEL.				
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME Donald Da					ADDRESS ELKTON, MD		25a. REC'D BY REGISTRAR DEC 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17396										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17407																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										Hour Min.																																							
Catherine Elizabeth Bacigalupo										Dec 19 68										8:30 P M																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.									
Female										White										4-1-92										76 YRS.										MONTHS DAYS HOURS MIN.																			
7d. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
N. York										USA																				Cecil																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Rising Sun										Calvert Manor N.H.										Domestic																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																			
Md.										Cecil										Rising Sun										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										21 hakeview Rd.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
John K. Kelly										Elizabeth Jane																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
No										330-54-9681										Calvert Manor N.H. Rising Sun Md																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) Pneumonia																																																											
4129																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																																																											
(b) A.S.H.D. & Generalized Arteriosclerosis																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
4200																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year P.M. 19																																																	
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION										Street or R.F.D. No. City or Town County State																													
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																																																											
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19 to Dec, 1968, that (I) (we) lost saw the deceased alive on Dec 19 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																													
Ernest W. Seiter M.D.																														Dec 20, 68																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Ernest W. Seiter										28 Cherry St. Rising Sun, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										DEC 23 1968										ST. JOHNS CEMETERY										BURENS MD																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Ernest M. Miller										Rising Sun, Md.										DATE DEC 27 1968										John Charles Judge																													

DEC 1 1968

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VR A15 (4)
30M REV. 1/68

17397		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				17408	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) MAX First B. Middle BERMAN Last			2a. DATE OF DEATH Month 12 Day 27 Year 1968			2b. HOUR 12 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-27-94		6. AGE (In years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) Holland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil County, Md.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hosp. Elkton		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY CHEMICAL	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York		13b. COUNTY NEW YORK		13c. CITY OR TOWN New York		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 112 W. 72nd St.		14. FATHER'S NAME First GEORGE Middle BERMAN Last		15. MOTHER'S MAIDEN NAME First JANSJE Middle SLAGER Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 136-18-3776		17. INFORMANT Address HENDRIKA G. BERMAN NEW YORK N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5339 Cardiac Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5400 Bleeding Peptic ulcer.							
19a. DATE OF OPERATION 12-27-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding peptic ulcer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-25-1968 , to 12-27-1968 , that (I) (we) last saw the deceased alive on 12-27-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Cristobal Vela, M.D.		22c. DATE SIGNED 12-28-68		22d. PHYSICIAN'S NAME (Type) CRISTOBAL VELA, M.D.		22e. ADDRESS 123 W. High St. Elkton.	
23a. BURIAL, CREMATION, REMOVED (Specify)		23b. DATE 12-30-68		23c. NAME OF CEMETERY OR CREMATORY GILPIN MANOR MEM. PK		23d. LOCATION (City or Town) (County) (State) ELKTON, CEIL, Md	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		ADDRESS ELKTON, Md		25a. REC'D BY REGISTRAR DEC 31 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17398

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17409

1. DECEASED-NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
CATHERINE MARIE BIRNEY						Month Day Year			12 4 1968			7:p M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Female	White	March 2, 1968	YRS. 9	MONTHS	DAYS	HOURS	MIN	Month Day Year			December 4 1968 7:p M			
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH						
Elkton, Md.		U.S.A.		WIDOWED		DIVORCED		Cecil			Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton			Union Hospital			XXXXXXX			XXXXXXXXXXXX					
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Cecil			Elkton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.D. 2 Elkton, Md.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Charles Coulter			Barbara Ann Birney											
160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			none			Barbara Ann Birney			R.D. #2, Elkton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis (SDII)</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
525X														
190. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
210. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH				HOUR A.M. P.M. 19										
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>														
220. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED						
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				12/5/68						
Ronald N. Kornblum, M.D.				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)						
230. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY						
Burial				Dec. 7, 1968				Cherry Hill Cemetery						
								23d. LOCATION (City or Town) (County) (State)						
								Cherry Hill Cecil Md.						
24. FUNERAL DIRECTOR				ADDRESS				250. REC'D BY REGISTRAR						
Pippin Funeral Home				Elkton, Md.				DATE DEC 9 1968						
								25b. REGISTRAR'S SIGNATURE						
								Charles Judge						

1. Name of plant	2. Name of grower	3. Name of collector	4. Name of collector
5. Name of collector	6. Name of collector	7. Name of collector	8. Name of collector
9. Name of collector	10. Name of collector	11. Name of collector	12. Name of collector
13. Name of collector	14. Name of collector	15. Name of collector	16. Name of collector
17. Name of collector	18. Name of collector	19. Name of collector	20. Name of collector
21. Name of collector	22. Name of collector	23. Name of collector	24. Name of collector
25. Name of collector	26. Name of collector	27. Name of collector	28. Name of collector
29. Name of collector	30. Name of collector	31. Name of collector	32. Name of collector
33. Name of collector	34. Name of collector	35. Name of collector	36. Name of collector
37. Name of collector	38. Name of collector	39. Name of collector	40. Name of collector
41. Name of collector	42. Name of collector	43. Name of collector	44. Name of collector
45. Name of collector	46. Name of collector	47. Name of collector	48. Name of collector
49. Name of collector	50. Name of collector	51. Name of collector	52. Name of collector
53. Name of collector	54. Name of collector	55. Name of collector	56. Name of collector
57. Name of collector	58. Name of collector	59. Name of collector	60. Name of collector
61. Name of collector	62. Name of collector	63. Name of collector	64. Name of collector
65. Name of collector	66. Name of collector	67. Name of collector	68. Name of collector
69. Name of collector	70. Name of collector	71. Name of collector	72. Name of collector
73. Name of collector	74. Name of collector	75. Name of collector	76. Name of collector
77. Name of collector	78. Name of collector	79. Name of collector	80. Name of collector
81. Name of collector	82. Name of collector	83. Name of collector	84. Name of collector
85. Name of collector	86. Name of collector	87. Name of collector	88. Name of collector
89. Name of collector	90. Name of collector	91. Name of collector	92. Name of collector
93. Name of collector	94. Name of collector	95. Name of collector	96. Name of collector
97. Name of collector	98. Name of collector	99. Name of collector	100. Name of collector

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17399

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17410

1. DECEASED-NAME (Type or print) <i>Andreanna</i>			First Middle Last			2a. DATE OF DEATH Month <i>12</i> Day <i>11</i> Year <i>1968</i>			2b. HOUR <i>9:20</i> AM		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Dec. 10, 1968</i>			6. AGE (In years last birthday) YRS. MONTHS DAYS <i>21</i>		
7a. BIRTHPLACE (State or foreign country) <i>md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Cecil County</i> Md.		
10. CITY OR TOWN OF DEATH <i>ELKTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Union Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>NONE</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>cecil</i>			13c. CITY OR TOWN <i>ELKTON</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME First <i>Arvil</i> Middle <i>A.</i> Last <i>Blankenship</i>			15. MOTHER'S MAIDEN NAME First <i>Alma</i> Middle <i>Whitt</i> Last <i>Whitt</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>			16b. SOCIAL SECURITY NO. <i>---</i>			17. INFORMANT <i>Arvil A. Blankenship R.D. #5</i>			Address <i>Providence Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hypoxia</i> <i>7701</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Abruptio placenta and prematurity</i> DUE TO, OR AS A CONSEQUENCE OF <i>Approx 80 wks gestation</i> (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 hrs</i> <i>30 hrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>7615 shoulder presentation. Delivered by version and extraction</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>12-10-1968</i> to <i>12-11-1968</i> , that (I) (we) last saw the deceased alive on <i>12-11-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Tillman D. Johnson M.D.</i>						DEGREE <i>M.D.</i>			22c. DATE SIGNED <i>12-19-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Tillman D. Johnson M.D.</i>						22e. ADDRESS <i>133 Singler Ave Elkton, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>12-16-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>ELKTON CEM</i>			23d. LOCATION (City or Town) (County) (State) <i>ELKTON, CEIL MD</i>		
24. FUNERAL DIRECTOR <i>Pippin Funeral Home</i>			ADDRESS <i>Elkton Md</i>			25a. RECEIVED BY REGISTRAR DATE <i>DEC 16 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Plante Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Lost	2a DATE OF DEATH Month 12 Day 23 Year 68		2b. HOUR 10:50	
CARL			C			BROOKS			
3. SEX Male		4 RACE Negro		5. DATE OF BIRTH 8-3-04		6. AGE (In years last birthday) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Cecil Md			
10 CITY OR TOWN OF DEATH Perry Point			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Veterans Administration			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) clerk		12b KIND OF BUSINESS OR INDUSTRY Unknown	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Dist. of Columbia			13b COUNTY Washington		13c INSIDE CITY, MTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 701 56th Place, NE		
14. FATHER'S NAME Joseph			First Middle Lost (D)		15. MOTHER'S MAIDEN NAME Nannie		First Middle Lost Howell (D)		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes give year or dates of service) WW II			16b SOCIAL SECURITY NO 577-07-6079		17 INFORMANT VA Hospital Records, Perry Point, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute</u> <u>4109</u> Ventricular fibrillation with pulmonary edema sudden									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>sudden</u> Coronary thrombosis, acute									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (this hospital) attended the deceased from <u>March 6</u> , 19 <u>68</u> , to <u>Dec. 23</u> , 19 <u>68</u> xxxxxx xxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE A. L. Mooney M.D.						22c. DATE SIGNED 12-24-68			
22d PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.						22e ADDRESS VA Hospital, Perry Point, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 12/28/68		23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park Maryland		23d LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR John T. Stewart						24b ADDRESS 4001 Benning		25b REGISTRAR'S SIGNATURE Charles Judge	
Stewart Funeral Home, Washington, DC						DATE DEC 31 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 and 388 and 389 and 390 and 391 and 392 and 393 and 394 and 395 and 396 and 397 and 398 and 399 and 400 and 401 and 402 and 403 and 404 and 405 and 406 and 407 and 408 and 409 and 410 and 411 and 412 and 413 and 414 and 415 and 416 and 417 and 418 and 419 and 420 and 421 and 422 and 423 and 424 and 425 and 426 and 427 and 428 and 429 and 430 and 431 and 432 and 433 and 434 and 435 and 436 and 437 and 438 and 439 and 440 and 441 and 442 and 443 and 444 and 445 and 446 and 447 and 448 and 449 and 450 and 451 and 452 and 453 and 454 and 455 and 456 and 457 and 458 and 459 and 460 and 461 and 462 and 463 and 464 and 465 and 466 and 467 and 468 and 469 and 470 and 471 and 472 and 473 and 474 and 475 and 476 and 477 and 478 and 479 and 480 and 481 and 482 and 483 and 484 and 485 and 486 and 487 and 488 and 489 and 490 and 491 and 492 and 493 and 494 and 495 and 496 and 497 and 498 and 499 and 500 and 501 and 502 and 503 and 504 and 505 and 506 and 507 and 508 and 509 and 510 and 511 and 512 and 513 and 514 and 515 and 516 and 517 and 518 and 519 and 520 and 521 and 522 and 523 and 524 and 525 and 526 and 527 and 528 and 529 and 530 and 531 and 532 and 533 and 534 and 535 and 536 and 537 and 538 and 539 and 540 and 541 and 542 and 543 and 544 and 545 and 546 and 547 and 548 and 549 and 550 and 551 and 552 and 553 and 554 and 555 and 556 and 557 and 558 and 559 and 560 and 561 and 562 and 563 and 564 and 565 and 566 and 567 and 568 and 569 and 570 and 571 and 572 and 573 and 574 and 575 and 576 and 577 and 578 and 579 and 580 and 581 and 582 and 583 and 584 and 585 and 586 and 587 and 588 and 589 and 590 and 591 and 592 and 593 and 594 and 595 and 596 and 597 and 598 and 599 and 600 and 601 and 602 and 603 and 604 and 605 and 606 and 607 and 608 and 609 and 610 and 611 and 612 and 613 and 614 and 615 and 616 and 617 and 618 and 619 and 620 and 621 and 622 and 623 and 624 and 625 and 626 and 627 and 628 and 629 and 630 and 631 and 632 and 633 and 634 and 635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) Harry					2a. DATE OF DEATH 12 Month 19 Day 68 Year					2b. HOUR 10²⁴ P.M.
3. SEX male		4. RACE white		5. DATE OF BIRTH MAY 25, 1895			6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) EIKTON, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil				
10. CITY OR TOWN OF DEATH EIKTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) OFFICE MANAGER		12b. KIND OF BUSINESS OR INDUSTRY Chemical		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN EIKTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 132 E. High Street	
14. FATHER'S NAME First Edward Middle J. Last Caldwell			15. MOTHER'S MAIDEN NAME First Richie Middle Denney Last Denney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war and dates of service) WW #1			16b. SOCIAL SECURITY NO. 212-03-4187		17. INFORMANT Mrs. Arrie D. Caldwell, EIKTON, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332x (b) cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 d. 10 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Bronchopneumonia										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec. 10, 1968 , to Dec. 19, 1968 ; that (I) (we) last saw the deceased alive on Dec. 19, 1968 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edgar E. Folkert, M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED Dec. 19, 1968					
22d. PHYSICIAN'S NAME (Type) Edgar E. Folkert					22e. ADDRESS 1155 Ave. "A", Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 22, 1968		23c. NAME OF CEMETERY OR CREMATORY EIKTON Cemetery		23d. LOCATION (City or Town) (County) (State) EIKTON Cecil Md.				
24. FUNERAL DIRECTOR Pippin Funeral Home, EIKTON, Md.					25a. RECD BY REGISTRAR DEC 23 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

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CERTIFICATE OF DEATH

17413

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital of Cecil County		d. STREET ADDRESS 216 Hollingsworth Manor	
3 NAME OF DECEASED (Type or print) Mrs. Helen E Coffin		4. DATE OF DEATH 12 3 19 68	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/17
9 AGE (n years last birthday) 51 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Cecil Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest Moore	
14. MOTHER'S MAIDEN NAME Annie Short		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO		17 INFORMANT Norman Coffin Jr. (Son) Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X Acute Cardiac Failure DUE TO (b) Emphysema DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1-Day 2-Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 5271			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 10/19/1968 to 12/3/1968 that (I) (we) last saw the deceased alive on 12/3/1968, and that death occurred at 6 A.M. from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson M.D.		22b. DATE SIGNED 12/3/68	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 E. High St., Elkton Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/7/68	23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	23d. LOCATION (City or Town) (County) (State) Elkton, Md.
24. FUNERAL DIRECTOR Ralph E. Hicks ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR DEC 13 1968	25b. REGISTRAR'S SIGNATURE J. Charles Judge



10.

11.

12.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
FELIX			COLLAZO			Month Day Year		12 21 1968	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c DATE PRONOUNCED DEAD		2d HOUR	
M	W	10/10/46	22 YRS			Month Day Year		12 21 1968	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
TOA ALTA, COCAZA			PUERTO RICO				CECIL		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
ELKTON, MD			Union Hospital			MUSIC ROOM LABORER		AGRICULTURE	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Penna			CHESTER			Kennett Square			
14. FATHER'S NAME First Middle Last			15 MOTHER'S M A D E N NAME First Middle Last						
HERMEREGILDO			COLLAZO			AVELINA RODRIQUEZ			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		
NO			583-09-9382		APOLONIO COLLAZO		333 ARCH ST CAMDEN, NEW JERSEY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries									
121 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
			9 50 P.M. 12/21 1968		passenger of auto involved in collision				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		State
Rt 280			Road		Rt 280, 3/4 mile south of PA state line				MD
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED			
WERNER U. SPITZ, M.D.						12.22.68			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER			
						ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL			12-27-68		TOA ALTO		TOA ALTA-PUERTO RICO		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
PIPPIN FURMAN			ELKTON			DEC 30 1968		J. Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1 DECEASED-NAME (Type or Print) CLIFFORD			First Middle Last GUY CONNER			2a DATE KNOWN OF DEATH Month Day Year 12-4 1968			2b HOUR M 12:25 A.M.		
3 SEX Male		4 RACE White		5 DATE OF BIRTH 6-3-20		6 AGE (in years last birthday) 48 YRS		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS HOURS MIN. 0 0	
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH CECIL		
10 CITY OR TOWN OF DEATH Elkton			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self-employed			12b KIND OF BUSINESS OR INDUSTRY Jeweler		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Cecil			13c CITY OR TOWN Colora			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last William D. Conner			15 MOTHER'S MAIDEN NAME First Middle Last Lucy Mary Stump			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If known, give dates of service) yes WW II			16b SOCIAL SECURITY NO 315-28-7300		
16c CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			17 INFORMANT Mrs. Jean L. Conner, Colora, Md.			ADDRESS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate			EXAMINER'S NAME (Type) Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED December 4, 1968		
23a. BURIAL CREMATION REMOVAL (Specify) Burial			23b. DATE Dec. 8, 1968			23c. NAME OF CEMETERY OR CREMATORY Goshen Cemetery			23d. LOCATION (City or Town) (County) (State) Port Deposit Cecil Md.		
24. FUNERAL DIRECTOR Lee A. Patterson, Jr.			ADDRESS Shyville			25a. REC'D BY REGISTRAR DEC 12 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First WILLIAM	Middle Stokely	Last DIX, Sr.	2a. DATE OF DEATH Month December Day 11 Year 1968		2b. HOUR 4:35 a.m. <input checked="" type="checkbox"/> M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH November 19, 1897		6. AGE (In years last birthday) 71 YRS		7. IF UNDER YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md				
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER --	
14. FATHER'S NAME First Middle Last Unknown					15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? Yes (If yes give war or dates of service) WW II			16b. SOCIAL SECURITY NO 217-54-9505		17. INFORMANT Address VA Hospital Records, Perry Point, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 1530 DUE TO, OR AS A CONSEQUENCE OF (b) Widespread metastatic tumor in liver & lungs DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Cecum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1530										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) VA		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that XX (this hospital) attended the deceased from April 29, 1964 to Dec. 11, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) (did) XXXXXX view the body after death										
22b. SIGNATURE A. L. Mooney, M.D.					22c. DATE SIGNED 12-11-68			22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-13-1968		23c. NAME OF CEMETERY OR REMOVAL Nelson Cemetery		23d. LOCATION (City or Town) (County) (State) New Church-Accomack-Va.				
24. FUNERAL DIRECTOR Watson Funeral Home, Pocomoke City, Md.					25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR Min		
LEE		Unk	DUNCAN		DECEMBER 4, 1968		11:00 PM		
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
MALE	NEGRO		MAY 18, 1911		57 YRS.				
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
	U.S.A.				CECIL		Md.		
10 CITY OR TOWN OF DEATH PERRY POINT		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 118 St. John Street	
14 FATHER'S NAME First Middle Last Jackson NMI Duncan		15. MOTHER'S M.A.DEN NAME First Middle Last Fannie Unk Duncan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		(If yes give year or dates of service) WW II		16b. SOCIAL SECURITY NO 230-10-8836		17 INFORMANT Address VA Hospital Records, Perry Point, MD 21902			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Malignancy from unknown primary site</u> 1791 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY) OFFICE BUILDING, ETC VA		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (the hospital) attended the deceased from Dec. 2, 1968, to Dec. 4, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) we (did) not view the body after death.									
22a. SIGNATURE E. E. Folk III				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-5-68			
22d. PHYSICIAN'S NAME (Type) E. E. FOLK III, M.D.				22e. ADDRESS VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-6-68		23c. NAME OF CEMETERY OR CREMATORY Berkeville Cemetery		23d. LOCATION (City or Town) (County) (State) Berkeville, Virginia			
24 FUNERAL DIRECTOR Phillips Funeral Home, Baltimore, Md.				25a. REC'D BY REGISTRAR DEC 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

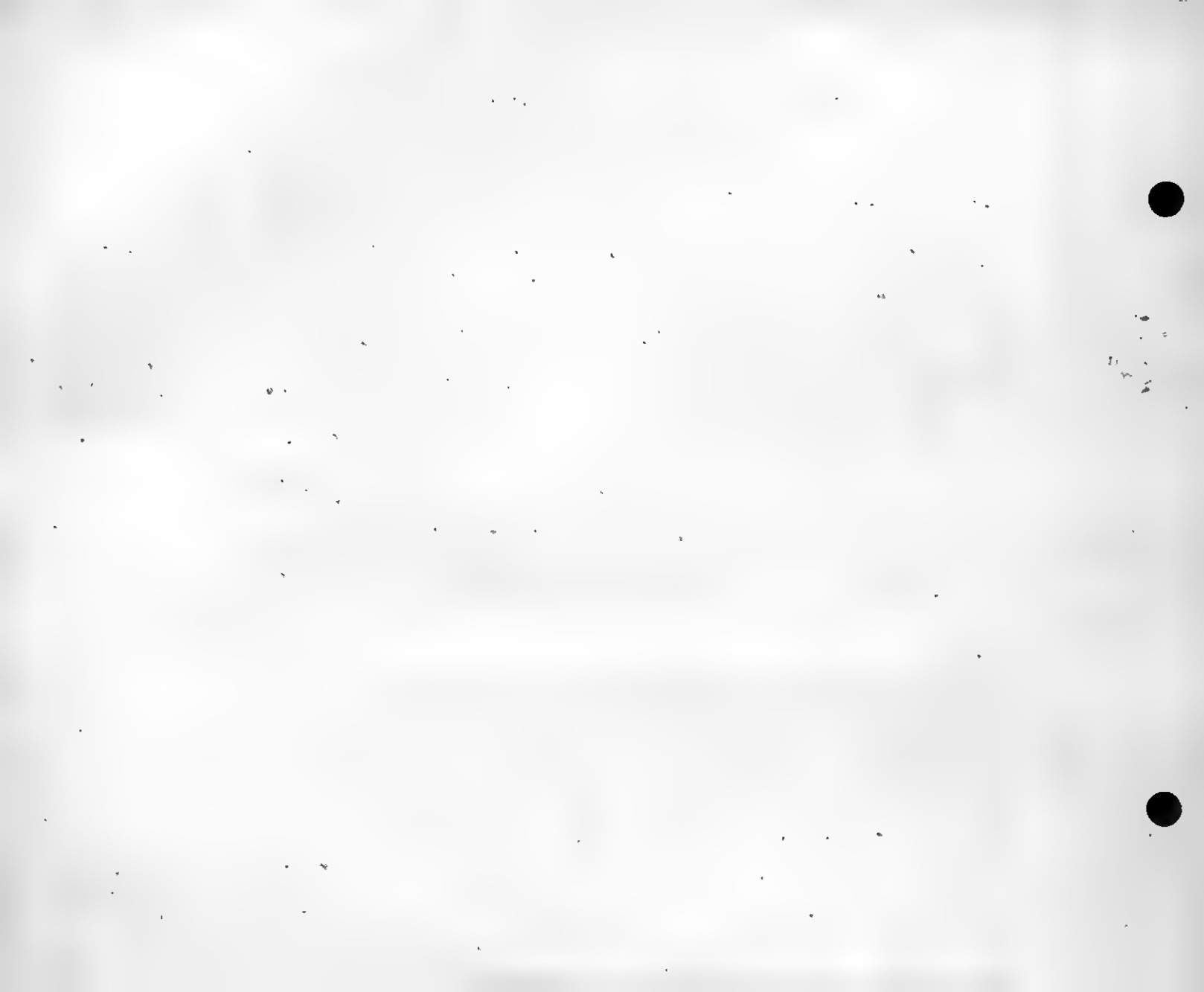


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-1-68
30M REV 1-68

17407		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17418	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) CORNELL			First Middle Last EBANKS		2a. DATE OF DEATH 12 Month 2 Day 68 Year
3 SEX M	4 RACE W	5. DATE OF BIRTH 10-24-93		6. AGE (in years last birthday) 75 YRS	2b. HOUR M
7a. BIRTHPLACE (State or foreign country) WEST INDIR	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CECIL		
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RET. CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY SELF
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.	13b. COUNTY CECIL	13c. CITY OR TOWN CHESAPEAKE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last DECES EBANKS		15. MOTHER'S MAIDEN NAME First Middle Last ROCHESTER KATES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT Address MRS. MARIE EBANKS CHESAPEAKE CITY, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 150X (b) Pneumonia and Lung Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Inoperable Ca of esophagus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 7 months 1 year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple Ca Metastasis - G.A.S. c/ A.S. CVD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from 10-27 , 19 68 , to 12-2 , 19 68 , that (I) (we) last saw the deceased alive on 12-2-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Luis M. Cuza M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-3-68	
22d. PHYSICIAN'S NAME (Type) LUIS M. CUZA, M.D.		22e. ADDRESS 322 E. Cecil Ave. North East, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-5-68	23c. NAME OF CEMETERY OR CREMATORY BETHEL		23d. LOCATION (City or Town) (County) (State) CHESAPEAKE CITY, MD	
24. FUNERAL DIRECTOR R.T. FORD FUNERAL HOME CITY, MD.		ADDRESS CHESAPEAKE		25a. REC'D BY REGISTRAR DEC 4 1968	25b. REGISTRAR'S SIGNATURE William J. Young



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

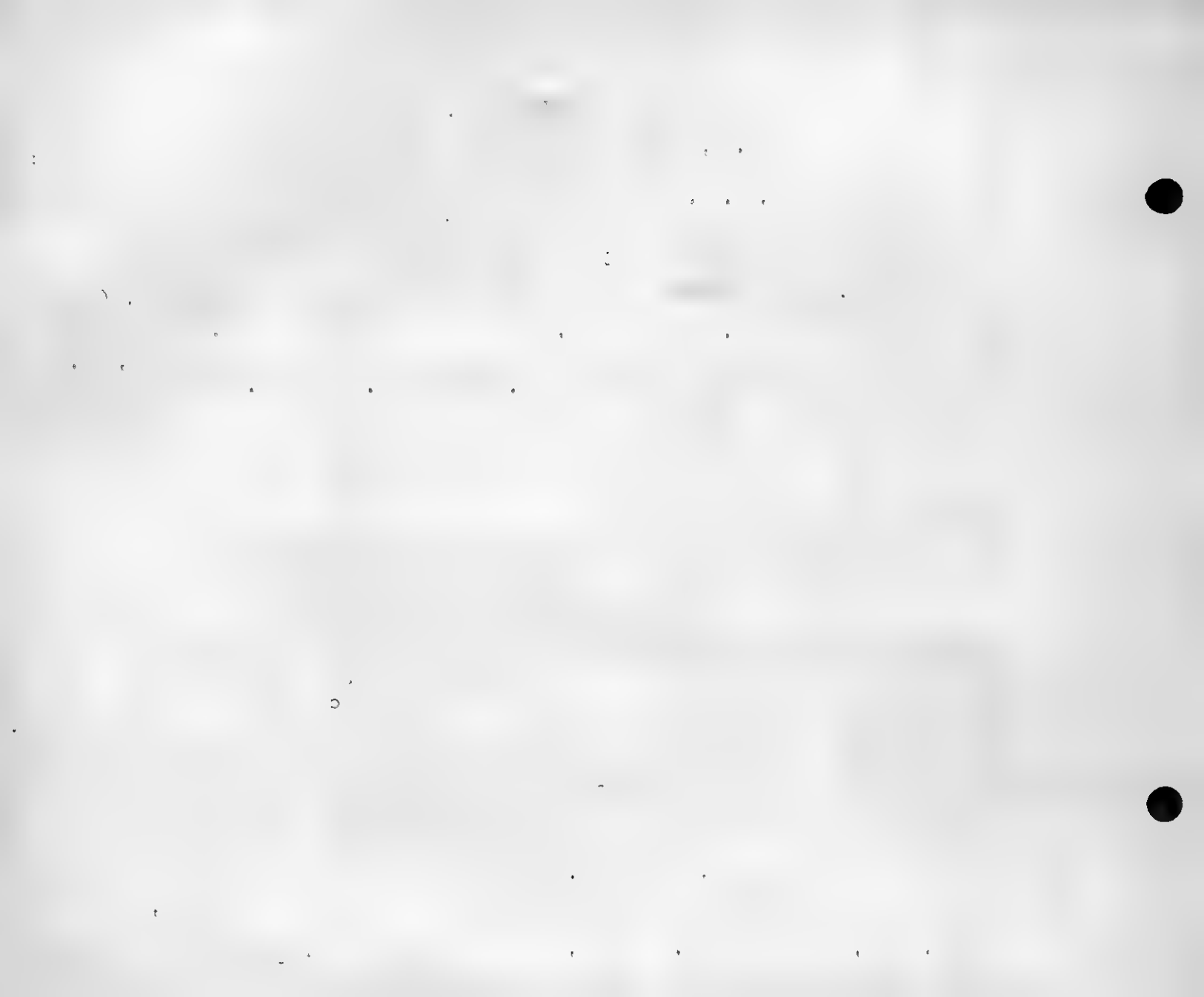
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

174198

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17419

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
THEODORE ROSCOE ERVIN JR.						12 4 19			68 11:50					
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 HRS	8. MARRIED	NEVER MARRIED	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD						
Male	White	Jan. 7, 1952	16 YRS	MONTHS DAYS HOURS MIN.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Cecil	Month Day Year 19 68 11:50						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED	9. COUNTY OF DEATH							
West Virginia		U. S. A.		<input type="checkbox"/>		<input type="checkbox"/>	Cecil Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY								
Conowingo		100 yds off Rock Springs		Student										
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
Md.		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8230 Kavanagh Rd. (Dundalk)						
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last					
Theodore R. Ervin Sr.						Alice J. Simmons								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Father)			ADDRESS					
No			216-58-2658			Mr. Theodore R. Ervin Sr.			8230 Kavanagh Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Gunshot wound of the brain														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) R.														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
719.														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? (HEAD) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 12 3 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
								Shot accidentally while hunting						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION (Street, R.F.D. No., City or Town, County, State)						
				Woods				100 yds off Rock Springs 50 yds off gastral Conowingo Cecil Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				M.D.				22b. DATE SIGNED						
EXAMINER'S NAME (Type)				Edward F. Wilson, M.D.				12/5/68						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY						
Burial				12/9/68				Oak Lawn Cemetery						
23d. LOCATION (City or Town) (County) (State)				23e. REC'D BY REGISTRAR				23f. REGISTRAR'S SIGNATURE						
Baltimore, Maryland				DEC 9 1968				John J. Duda						
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR						
John J. Duda, 7922 Wise Ave. Dundalk, Md.								DATE DEC 9 1968						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print) <i>Matthew Ficklin</i>						2a DATE OF DEATH Month <i>Dec</i> Day <i>28</i> Year <i>1968</i>			2b. HOUR M				
3 SEX <i>Male</i>		4 RACE <i>Negro</i>		5 DATE OF BIRTH <i>Aug, 23, 1890</i>			6 AGE (In years last birthday) <i>78</i> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS M.N.		8 UNDER 24 HRS.		
7a BIRTHPLACE (State or foreign country) <i>Va.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Cecil</i>			Md.	
10 CITY OR TOWN OF DEATH <i>Port Deposit</i>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Rt. 222</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>				13b COUNTY <i>Cecil</i>		13c CITY OR TOWN <i>Port Deposit</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt. 222</i>			
14. FATHER'S NAME First Middle Last <i>Unknown</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>				16b. SOCIAL SECURITY NO. <i>218-52-2971</i>		17 INFORMANT Address <i>Social Services Records, Elkton, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis - Cardiovascular</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Multiple Arteriosclerosis, Chronic Bronchitis</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 19 <i>60</i> , to <i>12/27</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Clarence I. Benson</i>						DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/29/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Clarence I. Benson, M. D.</i>						22e. ADDRESS <i>Port Deposit, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>1-1-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baptist Church Cem.</i>				23d. LOCATION (City or Town) (County) (State) <i>Chesapeake Cecil Md.</i>			
24. FUNERAL DIRECTOR <i>Lee C. Patterson</i>						ADDRESS <i>501 Perryville Hwy</i>		25a. REC'D BY REGISTRAR <i>AN 7</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17410 CERTIFICATE OF DEATH 17421										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR A M		
THOMAS H. FIELDS, SR.						December 3, 1968		8:35		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Negro		June 9, 1892		76 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.				Cecil				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Perry Point			VA Hospital			Trackman - Retired		Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Cecil		Port Deposit				14 Race Street	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
WILLIAM J. FIELDS			HANNA P. BROWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
Yes			WW I		717 07 56 44 VA Records, VAH, Perry Point, Maryland					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive pulmonary embolus</u>									Sudden	
4 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (b) <u>Phlebothrombosis of deep leg veins, rt. side</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
463x Arteriosclerotic coronary heart disease with generalized debility										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from <u>10-21-</u> , 19 <u>68</u> , to <u>12-3-</u> , 1968, that (we) last saw the deceased alive on <u>12-3-</u> , 1968, and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) <u>not</u> view the body after death.										
22b. SIGNATURE <u>A. L. Mooney M.D.</u> DEGREE					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12-3-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>A. L. MOONEY, M.D. Path.</u>					22e. ADDRESS <u>VA Hospital, Perry Point, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL, OR OTHER		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Removed</u>		12-3-68		<u>Cokesberry, Md.</u>		<u>Cokesberry Cecil Md.</u>				
24. FUNERAL DIRECTOR <u>Patterson & Son Perryville, Md.</u>					25a. FILED BY REGISTRAR <u>DEC 6 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First JOHN		Middle I.		Last GILBRIDE		2a. DATE OF DEATH Month 12 Day 5 Year 68		2b. HOUR 8:20	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 7-24-92			6 AGE (In years last birthday) 76 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Delaware			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Cecil Md				
10 CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Delaware			13b. COUNTY Rehoboth Beach		13c CITY OR TOWN Rehoboth Beach		13d INS DE CTY. MHS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 26 Wilmington Avenue			
14 FATHER'S NAME First John			Middle (D)		Last May		15. MOTHER'S MAIDEN NAME First May			Middle Crumlish (D)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) Yes			(If yes give year or dates of service) WW I		16b SOCIAL SECURITY NO 221-22-4045		17. INFORMANT Address VA Hospital Records, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Questionable coronary occlusion												
4109 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
4201												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 18 , 19 68 , to Dec. 5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <i>T. Guevara</i>						22c. DATE SIGNED 12-5-68		22d. PHYSICIAN'S NAME (Type) T. GUEVARA, M.D.				
22e. ADDRESS VA H. Perry Point, Md.						22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						
23a. B. RIAL, CREMATION, REMOVAL (Specify)			23b. DATE 12-7-68		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery			23d. LOCATION (City or Town) Wilmington Newcastle		(County) D. I. State		
24. FUNERAL DIRECTOR Page Wilson						ADDRESS Delaware		25a. REC'D BY REGISTRAR DEC 11 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
Page Wilson Funeral Home, Rehoboth Beach, Md.												

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR					
CLARENCE			GOAD			12 5 1968			11:45					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR			
Male	White	Feb. 7, 1912	56 YRS.					December 5, 1968			11:45			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH			Ma		
Virginia			U.S.A.						Cecil					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
North East			On Carbon Lane in trailer			University of Del			employee					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Del.			Castle			Wilmington			YES			824 W. 9th St.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
Harvey			Goad			Rosa			Bolt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS					
Yes			WIL 2			Mr. Edgar Goad, North East, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardio-														
1120 DUE TO, OR AS A CONSEQUENCE OF vascular disease														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)														
445X														
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH				19 P.M.										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						12/6/68		
Edward F. Wilson, M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
						ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			12/3/68			Goad Cemetery			Carroll Co. Virginia					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Ralph E. Hicks						DEC 13 1968			J Charles Judge					
Hicks Home for Funerals, Elkton, Md.														

17413

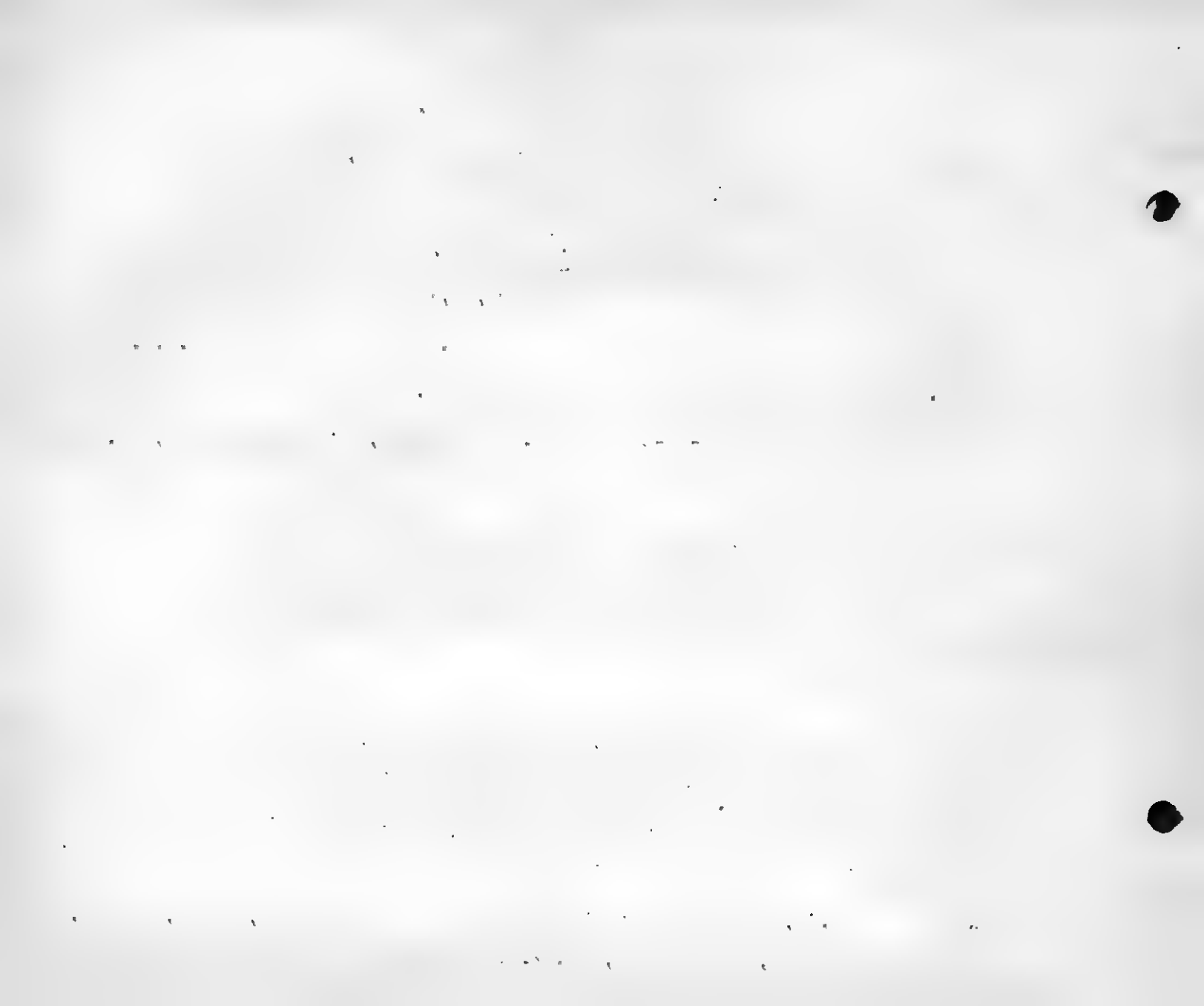
CERTIFICATE OF DEATH

Reg. Dist. No. 17424

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANDREW First Jackson Middle GREENE Last		4. DATE OF DEATH Month 12 - Day 26 Year 1968	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 21, 1906
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John H. Greene	
14. MOTHER'S MAIDEN NAME Martha J. Allen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO 217-12-3173		17. INFORMANT Mrs. John Hessey, Chesapeake City, Md. 21915	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC PULMONARY INSUFFICIENCY DUE TO 492 X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC EMPHYSEMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Chesapeake City, Md.		20g. (County) (State)	
21. I certify that I attended the deceased from 12/17 , 19 68 , to 12/26 , 19 68 , that I last saw the deceased alive on 12/25 , 19 68 , and that death occurred at 6:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD DATE SIGNED 12/27/68			
ACTUAL SIGNATURE Henry V. Davis MD		M.D. CHESAPEAKE CITY MD	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 29, 1968	22c. NAME OF CEMETERY OR CREMATORY Johntown Cemetery	22d. LOCATION (City, town, or county) (State) Earleville, Cecil, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows & Son, Millington, Md. 21651		24a. REC'D BY REGISTRAR DEC 30 1968	
24b. REGISTRAR'S SIGNATURE Charles Judge			

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be bound with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17425

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institut an Residence before adm,ssion) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast		d. STREET ADDRESS RD # 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Albert AKA Middle Grussenmeyer Last Grussenmeyer		4 DATE OF DEATH Month 12- Day 19- Year 1968					
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1895	9 AGE (In years last birthday) 73 yrs	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming		11 BIRTHPLACE (State or foreign country) Delaware		12. COUNTRY OF WHAT COUNTRY? USA	
13. FATHER'S NAME Grussenmeyer Nicholas Grussenmeyer				14. MOTHER'S MAIDEN NAME Anna May Meyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO 218 18 8818		17. INFORMANT Mr. Joseph N. Mahoney Wilm., Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-19-68	
EXAMINER'S NAME (Type) <u>Tillman D. Johnson M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>123 Singers Ave. E/Hatton</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/1968		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Wilmington N.C. Del.	
24. FUNERAL DIRECTOR <u>William J. Warwick</u> ADDRESS <u>Newark, Delaware</u>				25a. REC'D BY REGISTRAR JAN 3 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

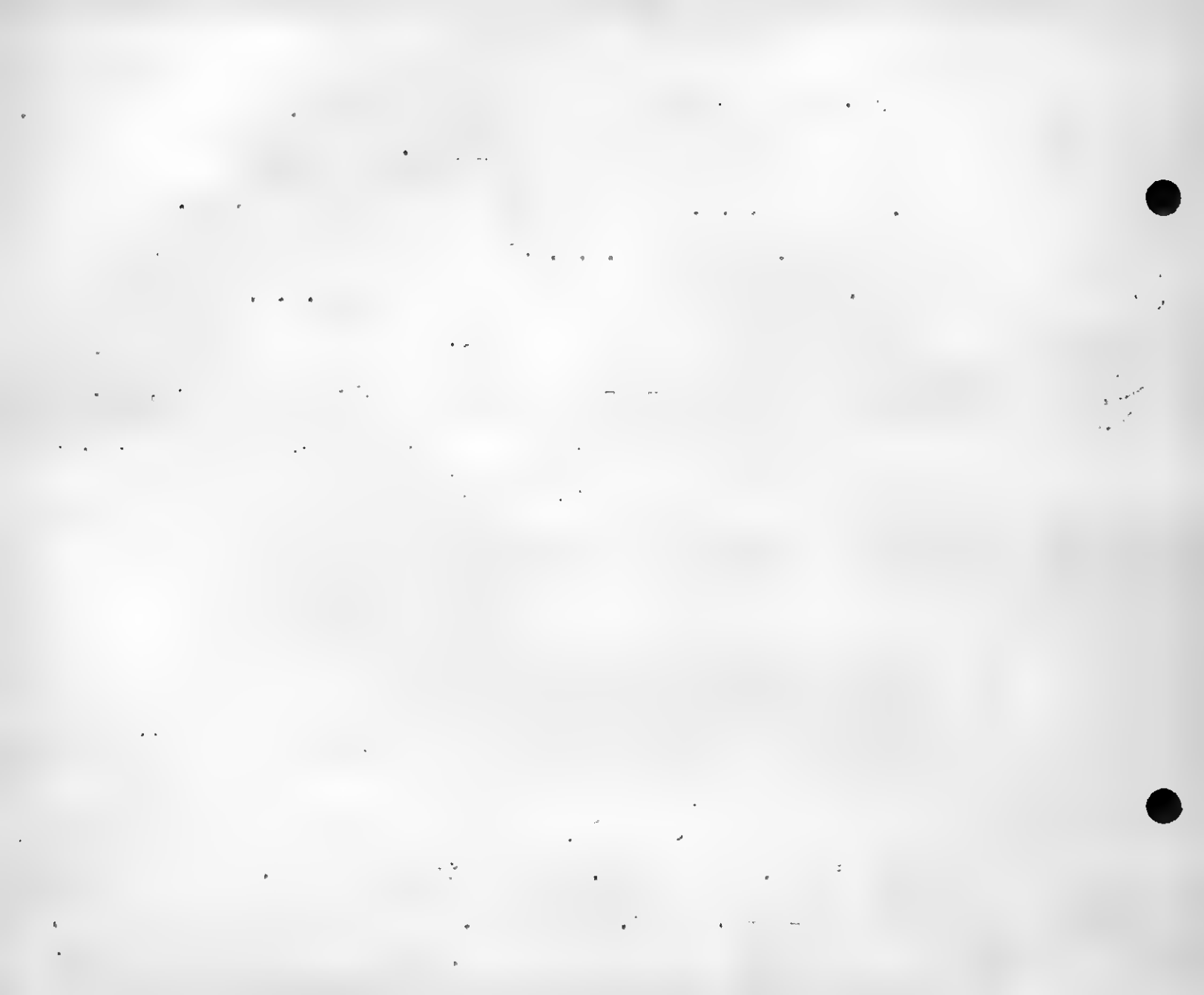
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17415

CERTIFICATE OF DEATH

17426

1. DECEASED-NAME (Type or print) Joseph Robertson Haines			2a. DATE OF DEATH Month Dec. Day 8 Year 1968		2b. HOUR 6A. M.
3. SEX Male	4. RACE Colored	5. DATE OF BIRTH 3-6-1881		6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Co. Md.	
10. CITY OR TOWN OF DEATH Conowingo Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D. #1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Labor	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Conowingo	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. # 1
14. FATHER'S NAME First Middle Last Joseph Haines			15. MOTHER'S MAIDEN NAME First Middle Last Maria Barnes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 213-12-5640A		17. INFORMANT Address Samuel Haines Conowingo, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF ASHO. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 hrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 42					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6-6 , 19 67 , to 12-7 , 19 68 , that (I) (we) lost saw the deceased alive on 12-7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Neil R. Taylor Jr.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-9-68	
22d. PHYSICIAN'S NAME (Type) Neil R. Taylor Jr.		22e. ADDRESS Rising Sun, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-11-1968	23c. NAME OF CEMETERY OR CREMATORY Mt. Zoar Cem.		23d. LOCATION (City or Town) (County) (State) Conowingo Cecil Md.	
24. FUNERAL DIRECTOR Jerome M. Mullen		ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR DEC 12 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

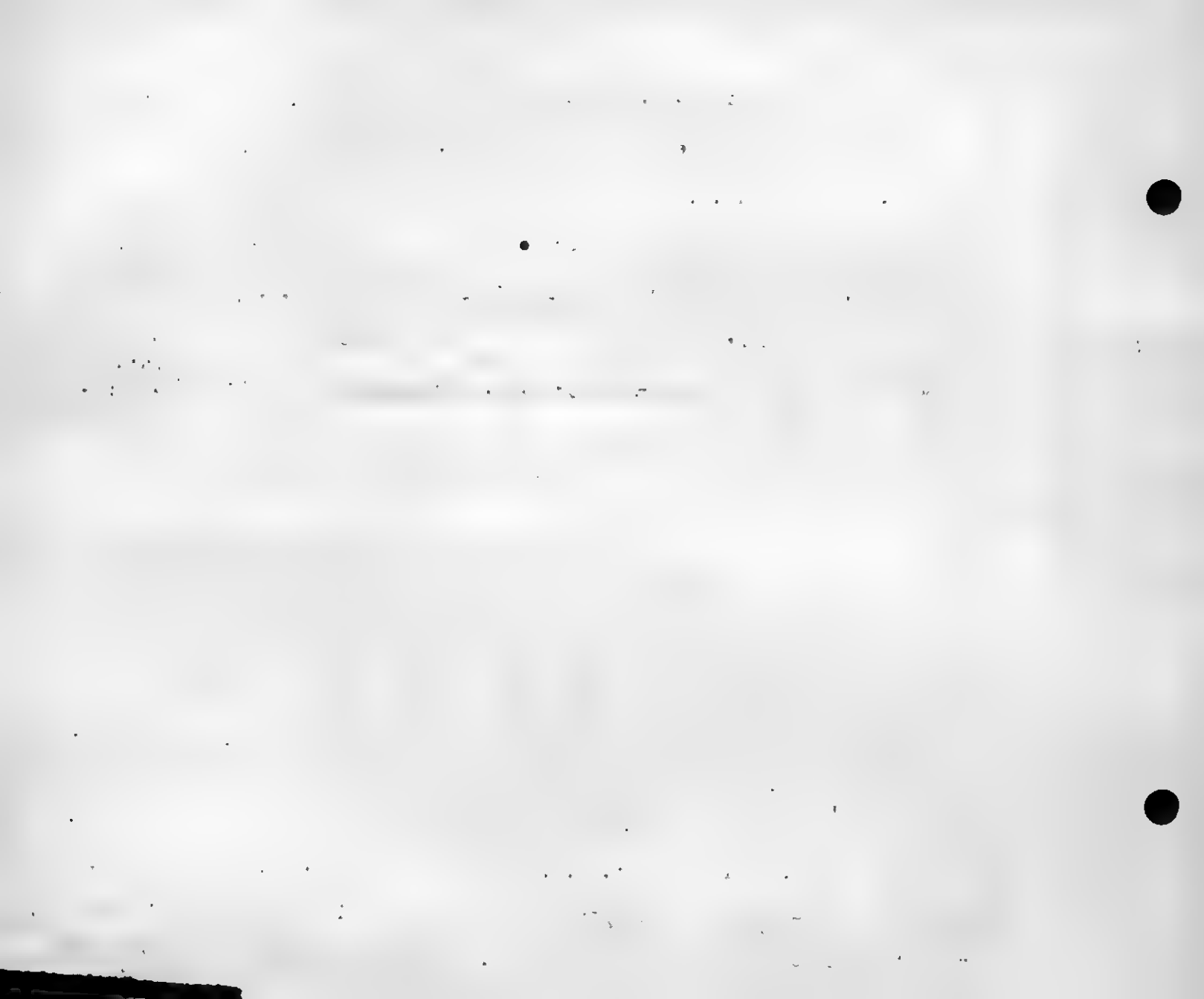


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/7-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
17416						17427					
1 DECEASED NAME (Type or print)						2a DATE OF DEATH			2b HOUR		
Dorothy M. Hanna						December 14 Day 1968 Year			1:10 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Dec. 24, 1885		82 (by day)		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U.S.A.				Cecil Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital			Housewife			Home		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.			Cecil		Perryville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. # 1		
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Steven Hickman				Mary Jewel							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17 INFORMANT			Address		
No				208-12-9453		Mrs. Mary Sibley			R.D. # 1 Perryville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4221</u>											
(b) <u>Arteriosclerotic cardiovascular disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Thrombosis + abdominal aortic aneurysm.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M.									
21d INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>12-9</u> 19 <u>68</u> , to <u>12-14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.	
<u>J.S. Barnhart, Jr. M.D.</u>						<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
22d PHYSICIAN'S NAME (Type)						22e ADDRESS		22c. DATE SIGNED			
J.S. Barnhart, Jr. M.D.						4 Mauldin Ave.		North East, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		12-18-68		Montrose Cemetery		Highland Park		Delaware		Pa.	
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Grant Funeral Home						DEC 18 1968		<u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Officer along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17428

DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year		2b. HOUR	
WILMER		RANDOLPH		HASSON				12 20 1968		12:20a	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
Male	White	June 13, 1903		65 YRS.						December 20 19 68 12:20	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Maryland		U.S.A.				Cecil					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if ret. red.)		12b. KIND OF BUSINESS OR INDUSTRY					
Elkton		Union Hospital		Laborer		Ck Paper Co					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Cecil		Childs				Childs, Maryland			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last									
Edward P. Hasson		Mary E. Founds									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS					
No		212-03-5402		Norman H. Hasson, Fort Deposit, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shotgun wound of the abdomen DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 9:10 AM 12 19 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		Shot accidentally by son who was cleaning					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No City or Town Childs, Md. his gun at the time Cecil Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 12/20/68					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		12/23/68		Ashbury Meth. Cemetery		Near Perryville, Cecil, Md.					
24. FUNERAL DIRECTOR Name (Type)		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
Ralph E. Hicks		Hicks Home for Funerals, Elkton, Md.		DEC 31 1968		J Charles Judge					



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in general item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

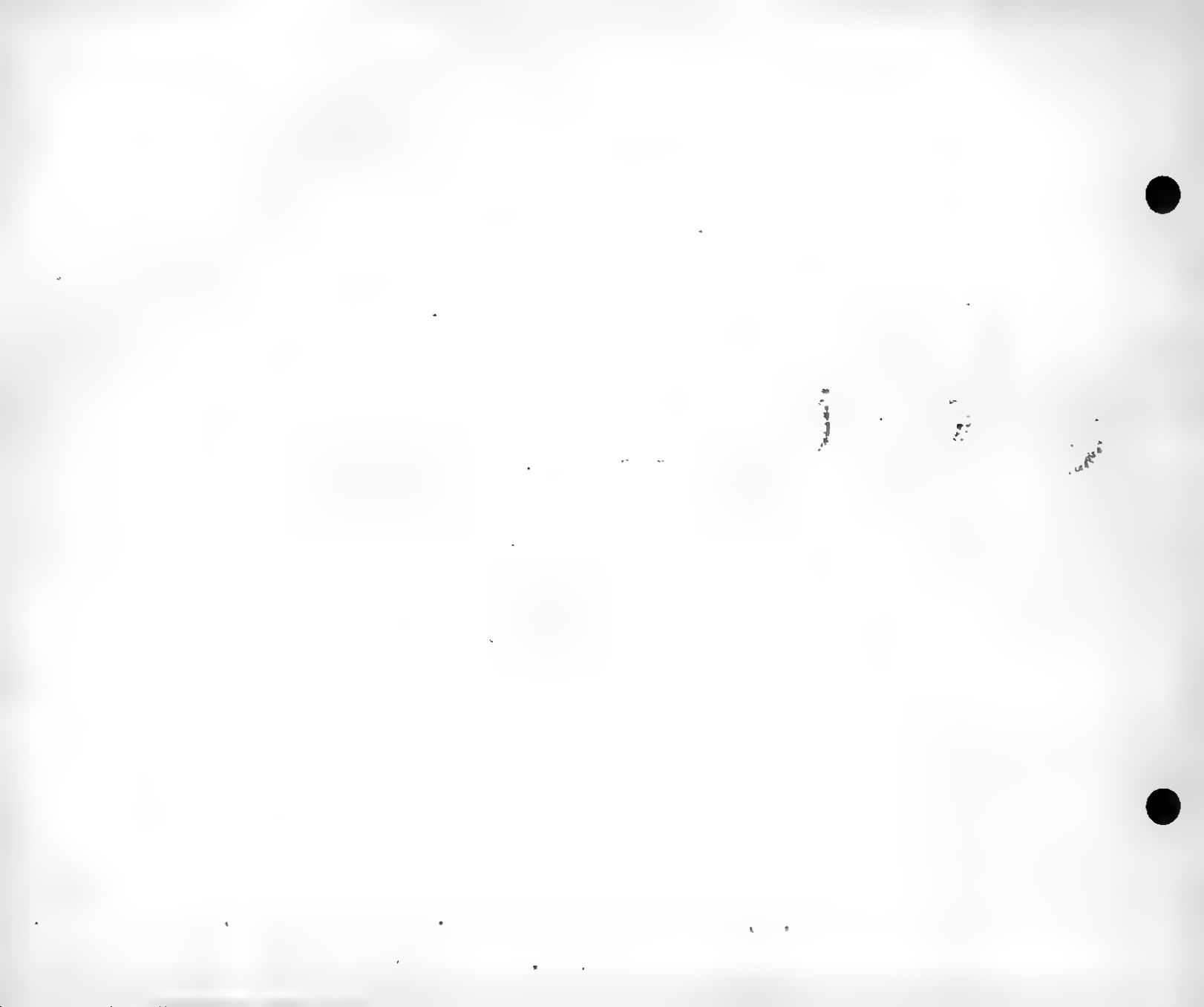
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17429

1. PLACE OF DEATH a COUNTY <u>CECIL</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>CECIL</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c LENGTH OF STAY IN 1b <u>5 MONTHS</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WARWICK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATHRYN</u> Middle <u>L.</u> Last <u>HEVELOW</u>				4 DATE OF DEATH Month <u>DEC</u> Day <u>14</u> Year <u>1968</u>			
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JAN 19 - 1904</u>	9 AGE (in years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>CHARLES LONG</u>			14 MOTHER'S MAIDEN NAME <u>EMMA TAYLOR</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>212-14-0696</u>		17 INFORMANT <u>HOSPITAL RECORDS</u> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>110x CARCINOMA OF LIVER AND PANCREAS</u> DUE TO (b) <u>CARCINOMA OF THYROID</u> DUE TO (c) <u>194x</u>							INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL MONTHS UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURED RT. FEMUR - 3/9/68</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>FELL IN FLOOR AT HOME ALONE</u>					
20c TIME OF INJURY Month, Day, Year <u>10 AM - 3/9 1968</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>HOME</u>		20f (City or town) (County) (State) <u>WARWICK CECIL MD</u>	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Henry V. Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Dec. 17, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Johntown Cemetery.</u>		23d. LOCATION (City or Town) (County) (State) <u>Earleville, Cecil Md.</u>	
24. FUNERAL DIRECTOR <u>Edward Fellows & Son, Millington, Md. 21651</u>				25a. REC'D BY REGISTRAR <u>DEC 20 1968</u>		25a REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**FOR STATE
HEALTH-DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3/ Page 5 may be retained for your files.
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17410

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17400

1. DECEASED-NAME (Type or Print)		First GEORGE		Middle William		Last HUGHES		2a. DATE KNOWN OF EST DEATH MATED <input type="checkbox"/> Dec. 7, 1968 8:00 P.M.		2b. HOUR P.M.	
3 SEX Male	4 RACE White	5. DATE OF BIRTH Dec. 7, 1945	6. AGE (In years last birthday) 23 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS M.N.		2c. DATE PRONOUNCED DEAD Month Dec Day 7 , Year 1968		2d. HOUR P.M.	
7a. BIRTHPLACE (State or foreign country) Darlington, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Cecil					
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. SOCIAL OCCUPATION (Kind of work done during most of working life, even if retired.) Buyer		12b. KIND OF BUSINESS OR INDUSTRY Logging					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Unk.			
14. FATHER'S NAME First John Middle H. Last Hughes				15. MOTHER'S MAIDEN NAME First Catherine Middle C. Last Schumm							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes, give year or dates of service) 1963		17. INFORMANT Mrs. John H. Hughes		ADDRESS Darlington, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. Unk. P.M. 12-4- 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Drowning while duck hunting							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Water		21f. LOCATION Street or R.F.D. No Unk.		City or Town Unk.		County Cecil		State M.D.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ronald N. Kornblum		EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED December 8, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 11, 1968		23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery		23d. LOCATION (City or Town) Darlington		(County) Harford		(State) Co. Md	
24. FUNERAL DIRECTOR John H. Harkins				ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR DATE DEC 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. Five pages (and 2 with the State Department of Health) prior to burial, cremation, or removal, and in any event within 72 hours after death.

17420

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) JAMES W. HUMPHRY			2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> 12 17 68			2b HOUR <input checked="" type="checkbox"/> ?	
3 SEX M	4 RACE W	5 DATE OF BIRTH 5-17-94	6 AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> 12 17 68	2d HOUR <input checked="" type="checkbox"/> 12
7a BIRTHPLACE (State or foreign country) DEL.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH CECIL	
10 CITY OR TOWN OF DEATH CAESAREAKE CITY		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GEORGE ST		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BARBER		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if not full-time residence before admission) STATE MD		13b COUNTY CECIL		13c CITY OR TOWN CAESAREAKE CITY		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First GEORGE Middle W Last HUMPHRY		15 MOTHER'S MAIDEN NAME First ANNIE Middle E. Last GEARY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b SOCIAL SECURITY NO NONE		17 INFORMANT GEORGE M. HUMPHRY		ADDRESS CECILTON, MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if only which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) SEVERAL HOURS YEARS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year August 8, 1968 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) FOUND IN BED AT HOME			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 117 NAME		21f LOCATION Street or RFD No City or Town County State GEORGE CAESAREAKE CITY MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Henry V. Davis MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) HENRY V. DAVIS MD		ADDRESS CAESAREAKE CITY MD		22b DATE SIGNED 12/17/68			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 12-15-68		23c NAME OF CEMETERY OR CREMATORY CECILTON		23d LOCATION (City or Town) (County) (State) CECILTON CECIL MD	
24 FUNERAL DIRECTOR R.T. FOARD		ADDRESS FUNERAL HOME CITY MD		25a REC'D BY REGISTRAR DEC 16 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

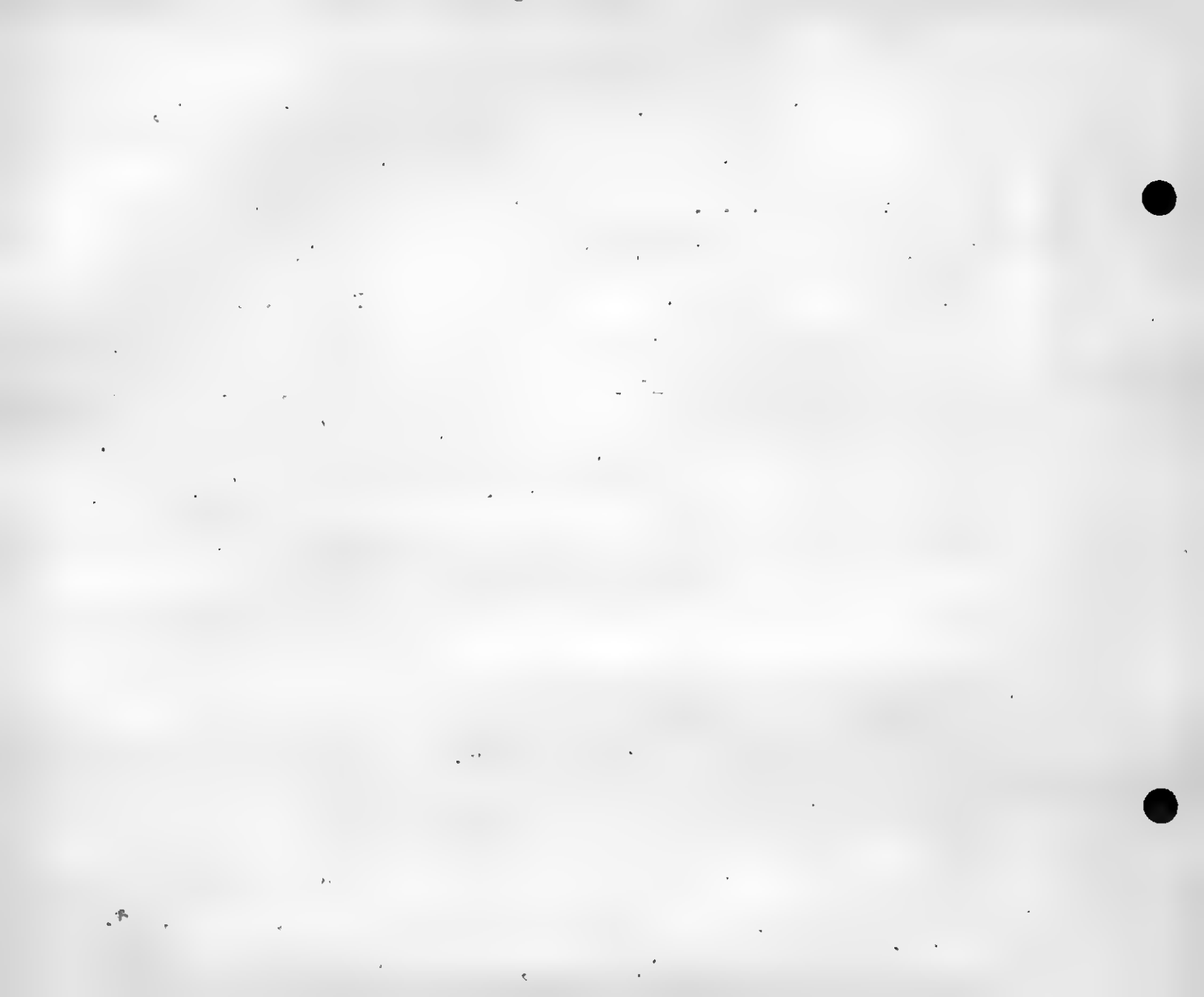
17432

10M REV 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																													
CERTIFICATE OF DEATH																													
1 DECEASED-NAME (Type or print)			First Ida			Middle L.			Last Jones			2a. DATE OF DEATH Month December			Day 27			Year 1968			2b. HOUR 7:30 PM								
3 SEX Female			4 RACE White			5 DATE OF BIRTH March 11, 1903			6 AGE (In years last birthday) 65 YRS.			F UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			HOURS			MIN.								
7a. BIRTHPLACE (State or foreign country) Kentucky			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Cecil Md.																				
10. CITY OR TOWN OF DEATH Elkton						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife						12b. KIND OF BUSINESS OR INDUSTRY --											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland						13b. COUNTY Cecil			13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER R.D. # 5														
14. FATHER'S NAME Albert						First Middle Last Little			15. MOTHER'S MAIDEN NAME Charlotta						First Middle Last Park														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No						(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 235-26-3370-A			17 INFORMANT Mrs. Peru Hill, Elkton, Md.						Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>																		1 day											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral sclerosis/heart disease</u>																		5 yrs.											
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
4201																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC						21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>64</u> , to <u>Dec 22</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>12/22</u> , 19 <u>68</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Joseph G. Lanzi</u>												DEGREE ATTENDING PHYS			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS			22c. DATE SIGNED 12/26/68											
22d. PHYSICIAN'S NAME (Type) Joseph G. Lanzi												22e. ADDRESS Elkton Medical Park Elkton, Maryland 21921																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE 12/27/68						23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.						23d. LOCATION (City or Town) (County) (State)											
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>												ADDRESS Hicks Home for Funerals, Elkton, Md.						25a. RECD BY REGISTRAR DATE JAN 1 1969						25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
30M REV. 11-68

17423

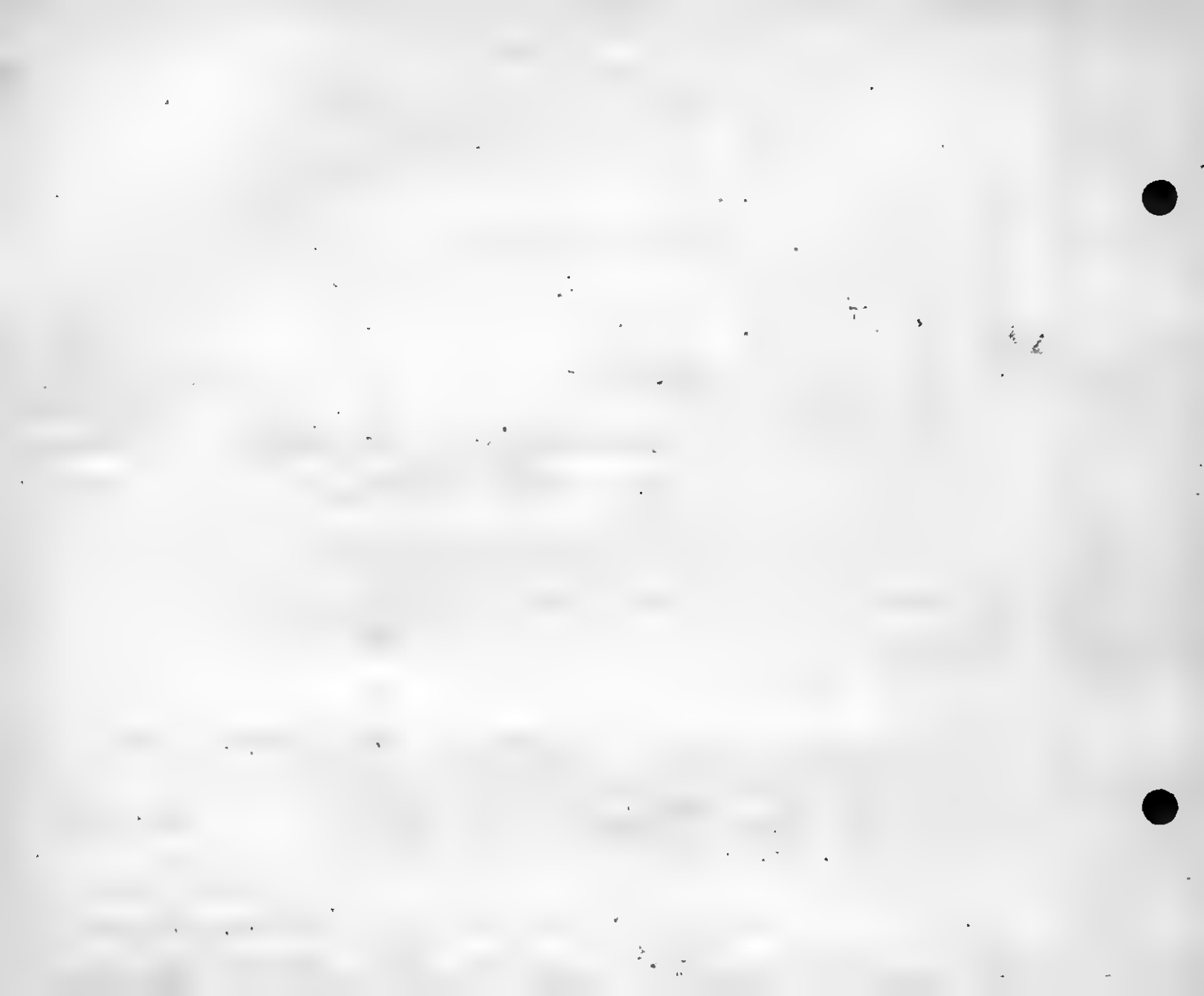
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17434

1. DECEASED NAME (Type or print) Anna First Maye Middle Lambdin Last			2a. DATE OF DEATH December Month 2 Day 1968 Year			2b. HOUR OF DEATH 3:35 P.M.					
3. SEX female		4. RACE white		5. DATE OF BIRTH 10-10-1883 ?		6. AGE (In years last birthday) 85 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Talbot, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.				
10. CITY OR TOWN OF DEATH Rising Sun, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Nursing Home Calvert Manor			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Work			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD			13b. COUNTY TALBOT			13c. CITY OR TOWN SHERWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First John Middle E. Last Willey			15. MOTHER'S MAIDEN NAME First Chambers Middle Sarah Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218-20-2856			17. INFORMANT William Burkhardt Address Rd. 2, Elkton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 231X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-1 , 19 68 , to 12-2 , 19 68 , that (I) (we) lost the deceased on 12-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Neil Taylor			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12-3-68					
22d. PHYSICIAN'S NAME (Type) Dr. Neil Taylor			22e. ADDRESS Rising Sun, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12/5/1968			23c. NAME OF CEMETERY OR CREMATORY Spring Hill			23d. LOCATION (City or Town) (County) (State) Easton, MD		
24. FUNERAL DIRECTOR THURICE E. NEWMAN, SON, ELKTON, MD			ADDRESS			25a. REC'D BY REGISTRAR DEC 5 1968			25b. REGISTRAR'S SIGNATURE John J. Jones		

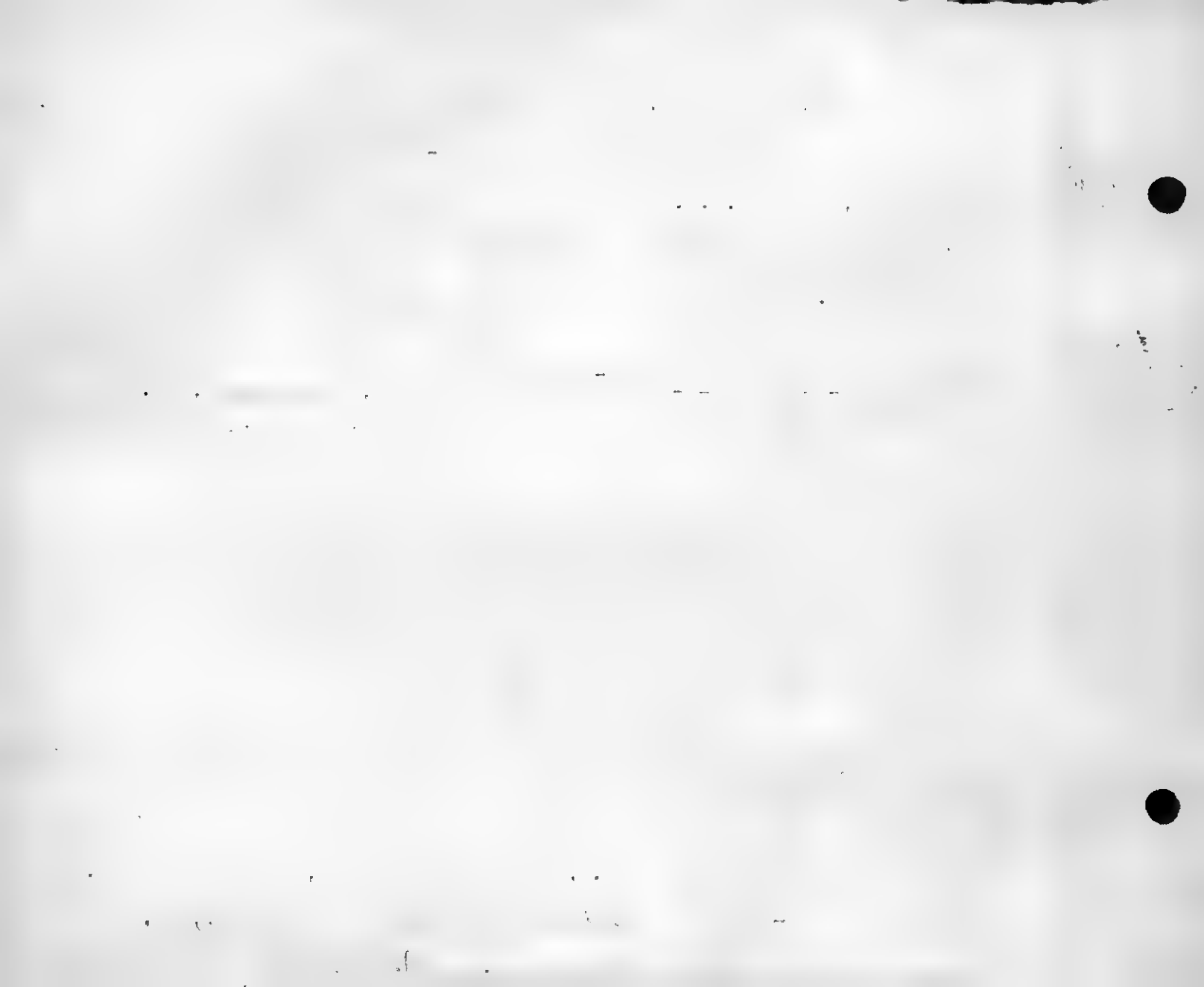
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
EARL			L. LAUGHNER			Month 12 Day 5 Year 68			1:15p		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		3-2-16		52 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
McKeesport, Pa		U.S.A.				Cecil Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Perry Point		Veterans Administration									
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Penna.						McKeesport		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4417 Second Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Adam (D)			Ella Ferdinand								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
Yes			189-10-5012			VA Hospital, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia both lower lobes-Aspiration</u> type <u>5-10 days</u>											
486X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
430X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from <u>May 3</u> , 19 <u>61</u> , to <u>Dec 5</u> , 19 <u>68</u> xxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>B. Rothfeld</u>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12 6 68</u>					
22d. PHYSICIAN'S NAME (Type)		BENJAMIN ROTHFELD, M.D.		22e. ADDRESS		VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		12-9-1968		Versailles Cemetery		McKeesport, Pa.					
24. FUNERAL DIRECTOR <u>See a Patterson & Co.</u>		ADDRESS <u>Perryville, Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
PATTERSON FUNERAL HOME - Perryville, Md.				DATE <u>DEC 12 1968</u>		<u>Charles Judge</u>					

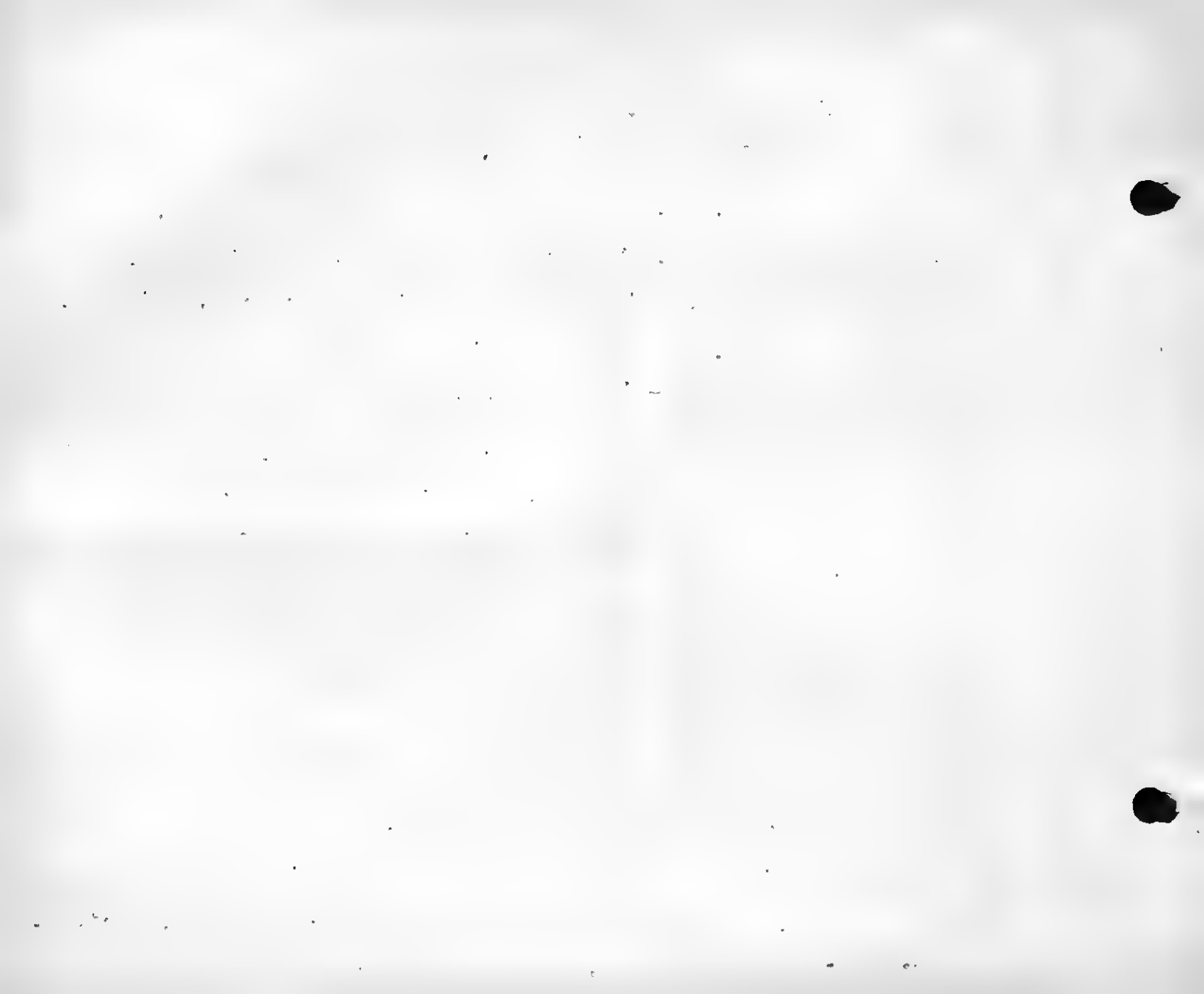


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
30M REV. 1/68

17425		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		17436	
CERTIFICATE OF DEATH					
1 DECEASED-NAME (Type or print) First Middle Last Walter L. Lewis			2a. DATE OF DEATH Month Day Year December 13 1968		2b HOUR M
3 SEX Male		4 RACE hite		5. DATE OF BIRTH September 17, 1919	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (In years last birthday) 49 YRS	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) President - Union Trucking	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton	
14 FATHER'S NAME First Middle Last Edward F. Lewis		15. MOTHER'S MAIDEN NAME First Middle Last Julian Ann Laws		12b. KIND OF BUSINESS OR INDUSTRY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO 218-09-1855		17 INFORMANT Hospital Records	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201 Calcific Aortic Stenosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>12-13, 1968</u> , that (I) (we) last saw the deceased alive on <u>12-13-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Williford Eppes</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 12-14-68	
22d PHYSICIAN'S NAME (Type) Williford Eppes		22e ADDRESS Newark, Delaware			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	
24 FUNERAL DIRECTOR <u>Walter E. Dickel</u>		ADDRESS Elkton, Maryland		25a REC'D BY REGISTRAR DATE DEC 23 1968	
				25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

17426

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17437

1. DECEASED-NAME (Type or print) First Middle Last Marlene E. Mars			2a. DATE OF DEATH Month Day Year December 3 1968			2b. HOUR 6 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 2, 1941		6. AGE (in years last birthday) 27 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 168 Hollingsworth Manor		14. FATHER'S NAME First Middle Last Arthur M. Murphy		15. MOTHER'S MAIDEN NAME First Middle Last Olive M. Wherry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO		17. INFORMANT Kenneth C. Mars, Elkton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MYIOMIA OF THE HEART + ASD</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>MI</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>66</u> , to <u>Dec.</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Dec 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Rolando A. Najera</u>				22c. DATE SIGNED 12/3/68			
22d. PHYSICIAN'S NAME (Type) Rolando A. Najera				22e. ADDRESS 105 E. Main St. Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/6/68		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City or Town) (County) (State) Elkton Md.	
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>				25a. REC'D BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 17438 17438 </div>										
<div style="display: flex; justify-content: space-between;"> Items 6 & 8 FilmG408 1/10/69 to CERTIFICATE OF DEATH </div>										
1 DECEASED-NAME (Type or print) ETHEL Kennedy						2a DATE OF DEATH Month 12 Day 28 Year 68		2b HOUR 9:45 A M		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 12-2-1879		6 AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		
7a BIRTHPLACE (State or foreign country) U.S.A.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Cecil				
10 CITY OR TOWN OF DEATH RISING SUN, MD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CALVERT HAVEN N.H.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD			13b COUNTY HALFORD		13c CITY OR TOWN ABERDEEN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Short Lane	
14 FATHER'S NAME First Middle Last James H. Kennedy M.D.				15 MOTHER'S MAIDEN NAME First Middle Last Ione Elliott						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)				16b SOCIAL SECURITY NO 215-56-4155		17 INFORMANT Nancy M. Simons, Alexandria, Va 22311				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 73-1-1 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 37, X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 6-7 , 19 68 , to 12-27 , 19 68 , that (I) (we) lost saw the deceased alive on 12-27 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Neil R. Taylor				DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12-28-68				
22d. PHYSICIAN'S NAME (Type) Neil R. Taylor				22e. ADDRESS Rising Sun, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE 30 Dec 68		23c. NAME OF CEMETERY OR CREMATORY Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Aberdeen, Maryland 21001				
24. FUNERAL DIRECTOR James B. Lango				ADDRESS Tarring Funeral Home		25a. REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE James B. Lango		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
MARY ANN			MUELLER			12 Month 27 Day 68		4:35 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
FEMALE		WHITE		9/15/1887		87 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
IOWA		US				CECIL Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
ELKTON			UNION			HOUSE WORK				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			CECIL		ELKTON				210 PARK CIRCLE	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
WILLIAM LINDEMAD			CATHERINE GERLACH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No			214-32-2470		RAYMOND MUELLER, ELKTON, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SARCOMA, OVARY, WITH METASTASES</u>									7 years	
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
17. _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/9</u> , 19 <u>68</u> , to <u>12/21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John A. Fischer</u>					DEGREE <u>MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>12/21/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>John A. Fischer</u>					22e. ADDRESS <u>ELKTON, Md.</u>					
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		12/23/1968		SPRING HILL		EASTON, MD				
24. FUNERAL DIRECTOR <u>MAURICE E. NEWMAN, SON, EASTON, MD</u>					25a. REC'D BY REGISTRAR <u>DEC 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17438

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17440

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH Month Day Year			2b HOUR
MARY JOSEPHINE NEASE						19			M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
female	white	Nov. 5, 1931	37 YRS					December 30, 1968	11:45 P.M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Tennessee		U.S.A.				Cecil Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Elkton			Union Hospital			Practical Nurse		Nursing	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY, MTS?	13e STREET AND NUMBER		
Maryland			Cecil		Elkton	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	P.O. Box 45		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Ernest					Sims	Charmie			Derting
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
no						Clinton Ray Nease, Elkton, Md.			
18 CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> <u>8199</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>8254</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR AM 6:05 P.M. 12/27/68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) involved in automobile accident			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street			21f LOCATION Street or R.F.D. No City or Town County State Cecil, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED 12/31/68	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		1/3/69		Pleasant Vale Cemetery		Green County, Tenn.			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Ralph E. Hicks			Hicks Home for Funerals, Elkton, Md.			JAN 9 1969		J. McNamee, Jr.	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

174420

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17441

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH MATED <input type="checkbox"/> 12 18 1968			2b HOUR 9:18a
MELVIN DERICKSON NUTTER									
3 SEX Male	4 RACE White	5 DATE OF BIRTH Aug. 27, 1906	6 AGE (in years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year December 18, 1968	2d HOUR 9:18a
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Cecil			Md.
10 CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Del.			13b COUNTY New Castle		13c CITY OR TOWN Newark		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1219 Nottingham Rd.
14. FATHER'S NAME First Middle Last Melvin D. Nutter			15 MOTHER'S MAIDEN NAME First Middle Last Carrie Derickson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give year or dates of service) WW 2		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS Newark, Del. Mrs. Viola F. Nutter 1219 Nottingham Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 12/18/68					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Dec. 21, 1968		23c NAME OF CEMETERY OR CREMATORY Sharps Cem.		23d LOCATION (City or Town) (County) (State) Fair Hill, Maryland			
24 FUNERAL DIRECTOR R. T. Jones		ADDRESS Newark, Delaware		25a REC'D BY REGISTRAR DEC 23 1968		25b REGISTRAR'S SIGNATURE Charles S. Jones			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 1967 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17442							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or Print)			First THOMAS			Middle ALAN			Last OSBORNE			2a DATE KNOWN OF DEATH Month Day Year 12 10 1968		2b HOUR M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH 11-1-49		6 AGE (In years last birthday) 19 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year December 11, 1968		2d HOUR 6:50 P.M.			
7a BIRTHPLACE (State or foreign country) Harford Co., Maryland				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH CECIL Md.					
10 CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Truck Driver				12b KIND OF BUSINESS OR INDUSTRY Dairy					
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Md.				13b COUNTY Harford				13c CITY OR TOWN Forest Hill				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 1811 Grafton Shop Road			
14 FATHER'S NAME First Middle Last William MAURICE Osborne						15. MOTHER'S MAIDEN NAME First Middle Last Nancy IRENE YALE											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 216-56-3006				17 INFORMANT FATHER B38-3P21 Mr. William M. Osborne				ADDRESS 1811 Grafton Shop Road Forest Hill, Maryland 21050					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-cranial injuries 816.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day Year HOLDCRM. 7:35 P.M. 12-10 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Found in dam Driver in auto which broke guardrail and									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Conowingo Dam				21f LOCATION Street or R.F.D. No City or Town County State Rte. 1 Decil Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Charles S. Springate				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED December 12, 1968					
EXAMINER'S NAME (Type) Charles S. Springate, M.D.								ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
								ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE DEC 14, 1968				23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d LOCATION (City or Town) (County) (State) Bel Air, Harford Co., Maryland 21014					
24. FUNERAL DIRECTOR Joseph William Foster W. Bradley Williams St. Bel Air, Maryland 21014								25a REC'D BY REG. STRAR DATE DEC 16 1968				25b REGISTRAR'S SIGNATURE J. Charles Judge					



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7-3

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
EARL THADDEUS PICKELL						DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 12/30 1968		3:30 P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
male	white	Sept. 7, 1890	78 YRS	MONTHS	DAYS	HOURS	MIN	December 30 1968		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12d. HOUR		
Pennsylvania		U.S.A.				Cecil		4:30 P.M.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng, i.e., even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital			Tax Collector		--		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
pennsylvania			11		Quarrysville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. 3	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Scott Pickell			Mary Keen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
unknown					STATE Police		NORTH EAST Md			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>										
4129 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4d2.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
			HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/31/68		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/2/69		New Providence U.C.C.		Shrewsbury Church Rd				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Farrar & Hicks		Elkton, Maryland		DATE JAN 9 1969		Farrar & Hicks				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17433										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17444																																							
Item 1 Film 3408 1/17/69 kk.										CERTIFICATE OF DEATH																																																	
1 DECEASED NAME (Type or print) First Middle Last William Henry M. Purdy, Jr.										2a. DATE OF DEATH Month Day Year 12 20 68										2b. HOUR 11:50 PM																																							
3 SEX Male										4 RACE White										5 DATE OF BIRTH Sept. 11, 1994										6 AGE (In years last birthday) 74 YRS.										7c UNDER 1 YEAR MONTHS DAYS										7d UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Cecil Md.																													
10. CITY OR TOWN OF DEATH Bkton										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Government Civilian										12b. KIND OF BUSINESS OR INDUSTRY Canal																													
13a. U.S.A. RESIDENCE (Where deceased lived, if at institution, Residence before admission) STATE Maryland										13b. COUNTY Cecil										13c. CITY OR TOWN Chesapeake City										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER Cecil St.																			
14 FATHER'S NAME First Middle Last William Henry Purdy										15 MOTHER'S MAIDEN NAME First Middle Last Mary A. Way										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO 1										17 INFORMANT Mrs. Ethel D. Purdy, Chesapeake City, Md.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC HYPERTENSIVE C.V. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR SEVERAL YEARS																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION NONE										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Dec 17, 1968, to Dec 20, 1968, that (I) (we) last saw the deceased alive on Dec 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Henry V. Davis MD										22c. DATE SIGNED 12/30/68										22d. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD										22e. ADDRESS CHESAPEAKE CITY MD.																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 12/24/68										23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery										23d. LOCATION (City or Town) (County) (State) Bethel, Cecil Md.																													
24 FUNERAL DIRECTOR Ralph E. Becker										24a. ADDRESS Hicks Home for Funerals, Bkton, d.										24b. REC'D BY REGISTRAR DEC 31 1968										24c. REGISTRAR'S SIGNATURE Charles Judge																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17434

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17445

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Mary			First Middle Last Esther Rawlings			2a. DATE OF DEATH 12 Month 7 Day 68 Year			2b. HOUR 4:55 P. M.		
3. SEX Female			4. RACE white			5. DATE OF BIRTH 2/6/84			6. AGE (In years last birthday) 84 YRS.		
7a. BIRTHPLACE (State or foreign country) md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Cecil		
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hosp. of Cecil Co.			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Secretary Ret. V.M.C.A.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm ssion) STATE md.			13b. COUNTY Cecil			13c. CITY OR TOWN Port Deposit			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER R.F.D. #1			14. FATHER'S NAME First Middle Last Robert K. Rawlings			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Maxwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. 219-30-5403			17. INFORMANT Robert Rawlings			Address Port Deposit		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 4009 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic heart disease and peripheral vascular disease											
19a. DATE OF OPERATION 11/2/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Thrombosis, blocked artery			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct 6, 1968 , to Dec. 7, 1968 ; that (I) (we) last saw the deceased alive on Dec 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edgar E. Folk III, M.D.						22c. DATE SIGNED Dec. 8, 1968					
22d. PHYSICIAN'S NAME (Type) Edgar E. Folk III, M.D.						22e. ADDRESS 1155 Ave. "A." Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 12-10-1968			23c. NAME OF CEMETERY OR CREMATORY Hopwell Cem.			23d. LOCATION (City or Town) (County) (State) Port Deposit Cecil Md.		
24. FUNERAL DIRECTOR James E. McMullen						25a. REC'D BY REGISTRAR Rising Sun, Md.			25b. REGISTRAR'S SIGNATURE Charles Judge		

17435

CERTIFICATE OF DEATH

17446

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 20 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. STREET ADDRESS RD# 2 Locust Point	
3. NAME OF DECEASED (Type or print) Cornelius F. SHANAHAN		4. DATE OF DEATH Month 12 / Day 14 / Year 1968	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/06
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 14 / Days 19 / Hours 68 / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBING		10b. KIND OF BUSINESS OR INDUSTRY Plumber	
11. BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Frank Shanahan		14. MOTHER'S MAIDEN NAME Mamie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 555-01-7734	
17. INFORMANT Mrs. Cornilus F. Shanahan-above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) SUSPECTED MYOLADIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19 to PARENT , 19 to 1968 , that (I) (we) last saw the deceased alive on Nov 19 68 , and that death occurred at 4 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert L. Gray		22b. DATE SIGNED 12/14/68	
22c. PHYSICIAN'S NAME (Type) Robert L. Gray, MD.		22d. ADDRESS 123 W. High St. Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/18/68	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City or Town) (County) (State) XXXX Wilmington, N.C. Del.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		25. REG'D BY REGISTRAR DEC 23 1968	
25a. REGISTRAR'S SIGNATURE W. L. Smith		25b. REGISTRAR'S SIGNATURE W. L. Smith	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all cases, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

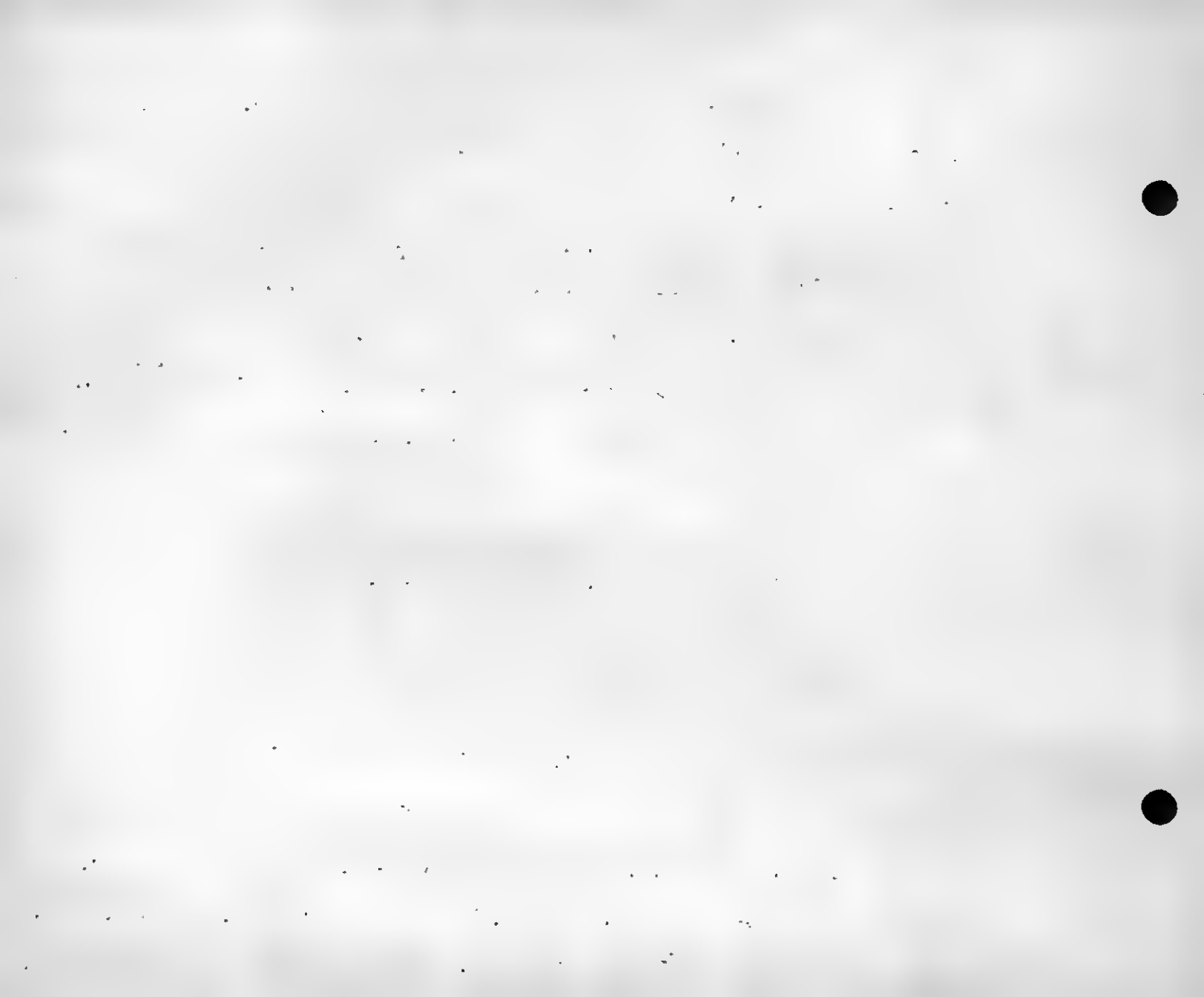
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17476

CERTIFICATE OF DEATH

17447

1. DECEASED NAME (Type or print) BERTHA A. SMITH			First Middle Last			2a. DATE OF DEATH Month Dec. Day 11 Year 1968			2b. HOUR 10:30 M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Sept. 11, 1874			6. AGE (In years last birthday) 94 YRS.		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.						
10. CITY OR TOWN OF DEATH North East			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. 1			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Registered nurse			12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Cecil			13c. CITY OR TOWN North East		13d. INSIDE CITY, IN 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D. # 1		
14. FATHER'S NAME First Edward Middle B. Last Smith			15. MOTHER'S MAIDEN NAME First Hanna Middle Guthrie Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 215-56-3467		17 INFORMANT Melvin A. Smith Address R.D. # 1 North East, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASHO DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 5 yrs.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 General consumption												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 6-6-1966 to 12-11-1968 , that (I) (we) last saw the deceased alive on 12-10-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Neil R. Taylor						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-13-68		
22d. PHYSICIAN'S NAME (Type) Neil R. Taylor M.D.						22e. ADDRESS 17 Haines Avenue Rising Sun, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-14-68		23c. NAME OF CEMETERY OR CREMATORY St. Mary Anne's				23d. LOCATION (City or Town) (County) (State) North East, Md. Cecil Md.				
24. FUNERAL DIRECTOR Grant Funeral Home		24b. ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						



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VR A15
MSM - 1-1-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Lyman			A.	Spence	Month 12 Day 3 Year 1968		8:40 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR			
Male		White		March 31, 1933		35 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Maryland		U.S.A.				Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Elkton			Union Hospital			Tourist					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Cecil		Elkton		YES		101 Stockton St.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
George			R.	Spence	Anna	Maria			McCullough		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			213-12-0928			Mrs. Ralph E. Hicks			Elkton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>											
4129 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4200</u>											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>1. Ca ascending colon & liver metastases. 2. Anemia, severe, malabsorption</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or RFD No		City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-30-1968</u> , to <u>12-5-1968</u> , that (I) (we) last saw the deceased alive on <u>12-5-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE						22c. DATE SIGNED					
<u>William D. Johnson</u>						12-5-68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
<u>William D. Johnson M.D.</u>						<u>123 Sinsbury Ave Elkton, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<u>Burial</u>		<u>12/9/68</u>		<u>Cherry Hill Meth. Cemetery, Cherry Hill, Md.</u>							
24. FUNERAL DIRECTOR						25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE			
<u>Ralph E. Hicks</u>						DATE <u>DEC 13 1968</u>		<u>J. Charles Judge</u>			
<u>Hicks Home for Funerals, Elkton, Md.</u>											

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VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) DEE			First Chancey Middle Mc Last SULLIVAN			2a. DATE OF DEATH Month 12 Day 11 Year 68		2b. HOUR 11:20 PM		
3 SEX Male		4 RACE White		5. DATE OF BIRTH 2-2-16		6. AGE (In years last birthday) 52 YRS		7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md				
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD #2, Box 298	
14. FATHER'S NAME First James Middle Wilson Last Sullivan (L)			15. MOTHER'S MAIDEN NAME First Anna Middle Mc Last Sturgill (L)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WW II			16b. SOCIAL SECURITY NO 202-03-3379		17. INFORMANT Address VA Hospital records, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Unknown DUE TO, OR AS A CONSEQUENCE OF (b) Peptic ulcer DUE TO, OR AS A CONSEQUENCE OF (c) Prostatitis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Nov. 3 , 19 68 , to Dec. 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S. Goldgraben					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-12-68			
22d. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.					22e. ADDRESS VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Sullivan Family Cemetery		23d. LOCATION (City or Town) (County) (State) LANSING, ASHE CO, NORTH CAROLINA		23e. ZIP CODE 28643		
24. FUNERAL DIRECTOR Foster Funeral Home					ADDRESS W. Broadway		25a. REC'D BY REGISTRAR DEC 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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17439

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17450

1. DECEASED-NAME (Type or print) CLYDE V. THREATT			20. DATE OF DEATH Month 12 Day 19 Year 68		2b. HOUR 12:45
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12-11-11		6. AGE (In years day birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New Jersey		13b. CITY OR TOWN Camden	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 2053 Westminster Avenue	
14. FATHER'S NAME First Middle Last Vanass Threatt		15. MOTHER'S MAIDEN NAME First Middle Last Hattie Magum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 294-03-0737		17. INFORMANT Address VA Hospital Records, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.)) (Trachea & Bronchi) by food particles PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete obstruction of air passageways DUE TO, OR AS A CONSEQUENCE OF Recurrent epileptic seizures (b) DUE TO, OR AS A CONSEQUENCE OF Skull fracture, old (1952) following a seizure (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3451					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 3533					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that XX (this hospital) attended the deceased from April 22 , 19 57 , to Dec. 19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. L. Mooney, M.D. DEGREE 22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.				22c. DATE SIGNED 12-20-68	
22e. ADDRESS VAH, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-21-1968		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery	
23d. LOCATION (City or Town) Charlotte, N.C.		(County)		(State)	
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR DATE DEC 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

11-11-11



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VR 153 (4)
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> 17440 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17451 </div> <div style="display: flex; justify-content: space-between;"> Item 8 Film G407 12/23/68 KK CERTIFICATE OF DEATH </div>											
1. DECEASED-NAME (Type or print) Raymond R. Zentz				2a. DATE OF DEATH Month December Day 7 Year 1968				2b. HOUR 1:16 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 27, 1900				6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.					
10. CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Golf Course			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 118 West Main St.	
14. FATHER'S NAME First Middle Last Allen Zentz				15. MOTHER'S MAIDEN NAME First Middle Last Catherine Groth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service) WW I				16b. SOCIAL SECURITY NO. 388-07-0365		17. INFORMANT Address Mrs. Estelle P. Zentz, Elkton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs. - 8 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1963 to Dec. 7, 1968 , that (I) (we) last saw the deceased alive on Dec. 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joseph G. Lanzi DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 12/10/68					
22d. PHYSICIAN'S NAME (Type) Joseph G. Lanzi						22e. ADDRESS Elkton Medical Park, Elkton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/12/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR ADDRESS Ralph E. Hicks 1111 Home for Funerals, Elkton, Md.						25a. REC'D BY REGISTRAR DATE DEC 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



1957

[Faint, illegible handwriting on lined paper]

